STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING _____	R 10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification, State Licensure and Quality Assurance Survey conducted on 07/30/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 10/01/12

Facility Number: 000544
Provider Number: 155673
AIM Number: 100267340

Surveyor: Amy Kelley, Life Safety Code Specialist

At this PSR survey, Markle Health and Rehabilitation was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the resident rooms on the 300 hall, in the corridors, and in areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms on the 100 and 200 halls. The facility has a capacity of 100 and had a census of 74 at the time of this survey.

The facility was found in compliance with state law in regard to sprinkler coverage and smoke

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING _____	R 10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 detector coverage. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds providing storage for activity and therapy supplies. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/03/12.	{K 000}		